MDR Tracking Number: M5-04-2304-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 3-24-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the therapeutic exercises, office visits, neuromuscular re-education, myofascial release, and joint mobilization from 3/24/03 through 4/09/03 were not medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity fees were the only fees involved in the medical dispute to be resolved. As the services listed above were not found to be medically necessary, reimbursement for dates of service 3/24/03 through 4/09/03 are denied and the Medical Review Division declines to issue an Order in this dispute.

This Decision is hereby issued this 7th day of June 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

RLC/rlc

May 18, 2004

MDR #: M5-04-2304-01
IRO Certificate No.: 5055

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine and is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services, EOB's
Carrier's correspondence, medical report 02/28/03
___ memo 03/24/03, impairment abstract 10/16/01
Clinical notes from ___, ___ and ___: 08/08/02 thru 04/10/03.
FCE/Nerve Conduction Study 05/08/01, 06/10/02, 02/12/03, 02/28/03.
Operative reports: 06/21, 06/28, 07/12, 08/23, 09/20, 12/20/2001, 02/07, 05/29, 08/15, 08/22, 11/13/2002.
CT lumbar spine 05/11/01, 04/19/02, discography report 04/18/02,

Clinical History:
The claimant was at work when he heard a pop in his low back and had sudden severe pain on ___. He has undergone prolonged rehabilitation. He has received an MRI and several epidural steroid injections. He has had minimal relief from this treatment.

Disputed Services:
Therapeutic exercises, office visits, neuromuscular re-education, myofascial release and joint mobilization during the period of 03/24/03 through 04/09/03.

Decision:
The reviewer agrees with the determination of the insurance carrier and is of the opinion that the treatment and services in dispute as stated above were not medically necessary in this case.

Rationale:
Based on the documentation provided, it is apparent the claimant has undergone prolonged rehabilitation and benefits of such treatment have not been significant.

The evaluation done on September 25, 2002 recommended a spinal fusion and said that further physical therapy did not seem to be of any benefit.

Referencing the Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters, chapter 8, page 125, the claimant is classified as a chronic/complicated case because of his symptoms having persisted beyond 16 weeks. Recommendations for care of this case are supervised rehab, which has already been attempted, and changes in lifestyle. Passive care is only recommended for acute conditions, which do not appear to be the situation in this case because no exacerbations of symptoms have been noted. Therefore, the treatment rendered between March 24th and April 29, 2003 to be reasonable and necessary in this situation.

Sincerely,